



X-linked agammaglobulinemia (XLA): Phenotype, diagnosis, and therapeutic challenges around the world



Zeinab A. El-Sayed^a, Irina Abramova^b, Juan Carlos Aldave^c, Waleed Al-Herz^d, Liliana Bezrodnik^e, Rachida Boukari^f, Ahmed Aziz Bousfiha^g, Caterina Cancrini^h, Antonio Condino-Netoⁱ, Ghassan Dbaibo^j, Beata Derfalvi^k, Figen Dogu^l, J.David M. Edgar^m, Brian Eleyⁿ, Rasha Hasan El-Owaidy^a, Sara Elva Espinosa-Padilla^o, Nermeen Galal^p, Filomeen Haerynck^{q,r}, Rima Hanna-Wakim^j, Elham Hossny^a, Aydan Ikinciogullari^l, Ebtihal Kamal^s, Hirokazu Kanegane^t, Nadia Kechout^f, Yu Lung Lau^t, Tomohiro Morio^u, Viviana Moschese^v, Joao Farelle Neves^w, Monia Ouederni^x, Roberto Paganelli^y, Kenneth Paris^z, Claudio Pignata^{aa}, Alessandro Plebani^{ab}, Farah Naz Qamar^{ac}, Sonia Qureshi^{ac}, Nita Radhakrishnan^{ad}, Nima Rezaei^{ae}, Nelson Rosario^{af}, John Routes^{ag}, Berta Sanchez^{ah}, Anna Sediva^{ai}, Mikko R.J. Seppanen^{aj}, Edith Gonzalez Serrano^o, Anna Shcherbina^b, Surjit Singh^{ak}, Sangeetha Siniah^{al,am,an}, Guiseppe Spadaro^z, Mimi Tang^{ao}, Ana Maria Vinet^{ap}, Alla Volokha^{aq}, Kathleen E. Sullivan^{ar,*}

^a Pediatric Allergy and Immunology Unit, Children's Hospital, Ain Shams University, Cairo, Egypt

^b Department of Immunology, National Medical and Research Center for Pediatric Hematology, Oncology and Immunology, Moscow, Russia

^c Primary Immunodeficiency Unit, Allergy and Immunology Division, Hospital Nacional Edgardo Rebagliati Martins, Lima, Peru

^d Department of Pediatrics, Faculty of Medicine, Kuwait University, Allergy and Clinical Immunology Unit, Al-Sabah Hospital, Kuwait City, Kuwait

^e Immunology Unit Hospital de Niños Ricardo Gutiérrez and CIC (Clinical Immunology Center), CABA, Buenos Aires, Argentina

^f Department of Immunology, Institut Pasteur d'Algérie, Faculty of Medicine, Algiers, Algeria

^g Clinical Immunology Unit, P1, Ibn Rushd Hospital, Laboratoire d'Immunologie Clinique, Inflammation et Allergie LICIA and Medicine and Pharmacy Faculty of Hassan II University, Casablanca, Morocco

^h University Department of Pediatrics, Unit of Immune and Infectious Diseases, Children's Hospital Bambino Gesù, "University of Rome Tor Vergata", Rome, Italy

ⁱ Department of Immunology, Institute of Biomedical Sciences, University of Sao Paulo, Sao Paulo – Sp, Brazil

^j Division of Pediatric Infectious Diseases and Center for Infectious Diseases Research, Department of Pediatrics and Adolescent Medicine, American University of Beirut, Beirut, Lebanon

^k Dalhousie University, IWK Health Centre, Halifax, Nova Scotia, Canada

^l Ankara University School of Medicine, Department of Pediatric Immunology and Allergy, Ankara, Turkey

^m The Royal Hospitals & Queen's University Belfast, United Kingdom

Abbreviations: CLD, Chronic lung disease; FH, Family history; GI, Gastrointestinal; JIA, juvenile idiopathic arthritis; SCIG, Subcutaneous immunoglobulin; VAPP, Vaccine associated paralytic poliomyelitis; XLA, X-linked agammaglobulinemia.

* Corresponding author. Division of Allergy and Immunology, Wallace Chair of Pediatrics, Director, Immunology Clinic, The Children's Hospital of Philadelphia, 34th Street and Civic Center Boulevard, Philadelphia, PA 19104-4399, USA.

E-mail addresses: zeinabawad@gmail.com (Z.A. El-Sayed), jucapul_84@hotmail.com (J.C. Aldave), wemh@hotmail.com (W. Al-Herz), lbezrodnik@yahoo.com.ar (L. Bezrodnik), rachida.boukari@yahoo.fr (R. Boukari), profbousfiha@gmail.com (A.A. Bousfiha), caterina.cancrini@opbg.net (C. Cancrini), antoniocondino@gmail.com (A. Condino-Neto), gdbaibo@aub.edu.lb (G. Dbaibo), beata.derfalvi@iwbk.nshealth.ca (B. Derfalvi), efdogu@yahoo.com (F. Dogu), david.edgar@belfasttrust.hscni.net (J.David M. Edgar), Brian.Eley@uct.ac.za (B. Eley), rashahasan@med.asu.edu (R.H. El-Owaidy), saraelvaespino@gmail.com (S.E. Espinosa-Padilla), nermeengalal@gmail.com (N. Galal), filomeen.haerynck@ugent.be (F. Haerynck), rh08@aub.edu.lb (R. Hanna-Wakim), elham.hossny@gmail.com (E. Hossny), aydani@medicine.ankara.edu.tr (A. Ikinciogullari), dr.ebtihal.kamal.ali@gmail.com (E. Kamal), hkanegane.ped@tmd.ac.jp (H. Kanegane), laulylung@hku.hk (Y.L. Lau), tmorio.ped@tmd.ac.jp (T. Morio), moschese@med.uniroma2.it (V. Moschese), joao.farelaneves@chlc.min-saude.pt (J.F. Neves), moniahasan@yahoo.fr (M. Ouederni), roberto.paganelli@unich.it (R. Paganelli), kparis@lsuhsc.edu (K. Paris), claudio.pignata@unina.it (C. Pignata), plebani@med.unibs.it (A. Plebani), farah.qamar@aku.edu (F.N. Qamar), sonia.qureshi@aku.edu (S. Qureshi), nitaradhakrishnan@yahoo.com (N. Radhakrishnan), rezaei_nima@yahoo.com (N. Rezaei), nelson.rosario@onda.com.br (N. Rosario), jroutes@mcw.edu (J. Routes), bersanchez@yahoo.es (B. Sanchez), Anna.Sediva@fnmotol.cz (A. Sediva), Mikko.Seppanen@hus.fi (M.R.J. Seppanen), megpetite@gmail.com (E.G. Serrano), shcher26@hotmail.com (A. Shcherbina), surjitsinghpgi@rediffmail.com (S. Singh), sang_8@yahoo.com (S. Siniah), giuseppe.spadaro@unina.it (G. Spadaro), Mimi.Tang@rch.org.au (M. Tang), anavire@gmail.com (A.M. Vinet), volokha@gmail.com (A. Volokha), sullivank@email.chop.edu (K.E. Sullivan).

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- ⁿ Paediatric Infectious Diseases Unit, Red Cross War Memorial Children's Hospital and the Department of Paediatrics and Child Health, University of Cape Town, Cape Town, South Africa
- ^o The Immunodeficiencies Research Unit, National Institute of Pediatrics, Mexico City, Mexico
- ^p Department of Pediatrics, Faculty of Medicine, Cairo University, Egypt
- ^q Primary Immunodeficiency Research Lab, Ghent University, Belgium
- ^r Centre for Primary Immunodeficiency, Department of Pediatric Pulmonology and Immunology, Ghent University Hospital, Belgium
- ^s Department of Microbiology, Parasitology and Immunology, Faculty of Medicine, University of Khartoum, Sudan
- ^t Department of Child Health and Development, Graduate School of Medical and Dental Sciences, Tokyo Medical and Dental University (TMDU), Tokyo, Japan
- ^u Department of Paediatrics and Adolescent Medicine, Queen Mary Hospital, The University of Hong Kong, Hong Kong, China
- ^v Pediatric Immunopathology and Allergology Unit, Tor Vergata University Hospital, University of Rome Tor Vergata, Rome, Italy
- ^w Primary Immunodeficiencies Unit, Hospital Dona Estefania, Centro Hospitalar de Lisboa Central and CEDOC Nova Medical School, Lisboa, Portugal
- ^x Pediatric Immuno-hematology Unit, Bone Marrow Transplantation Center, University Tunis El Manar, Faculty of Medicine, Tunis, Tunisia
- ^y Department of Medicine and Sciences of Aging, University "G. d'Annunzio" of Chieti-Pescara, Italy
- ^z LSU Health Sciences Center, New Orleans, LA, USA
- ^{aa} Department of Translational Medical Sciences, Section of Pediatrics, Federico II University, Naples, Italy
- ^{ab} Pediatrics Clinic and Institute for Molecular Medicine A. Nocivelli, Department of Clinical and Experimental Sciences, University of Brescia and ASST-Spedali Civili of Brescia, Brescia, Italy
- ^{ac} Department of Pediatric and Child Health, Aga Khan University Hospital, Karachi, Pakistan
- ^{ad} Department of Pediatric Hematology Oncology, Super Speciality Pediatric Hospital and PG Teaching Institute, Noida, India
- ^{ae} Research Center for Immunodeficiencies, Children's Medical Center, Tehran University of Medical Sciences, and Network of Immunity in Infection, Malignancy and Autoimmunity (NIIMA), Universal Scientific Education and Research Network (USERN), Tehran, Iran
- ^{af} Federal University of Parana, Curitiba, Brazil
- ^{ag} Division of Allergy and Clinical Immunology, Department of Pediatrics, Medical College of Wisconsin, Milwaukee, WI, USA
- ^{ah} Servicio de Inmunología, Hospital Universitario Virgen del Rocío, Seville, Spain
- ^{ai} Department of Immunology, 2nd Faculty of Medicine, Charles University and Motol University Hospital, Prague, Czech Republic
- ^{aj} Rare Diseases Center, Children's Hospital and Adult Immunodeficiency Unit, Infectious Diseases, Inflammation Center, University of Helsinki and Helsinki University Hospital, Helsinki, Finland
- ^{ak} Department of Pediatrics and Chief, Allergy Immunology Unit, Advanced Pediatrics Centre, Post Graduate Institute of Medical Education and Research (PGIMER), Chandigarh, India
- ^{al} Paediatric Institute Kuala Lumpur General Hospital, Kuala Lumpur, Malaysia
- ^{am} Department of Allergy and Immunology, The Royal Children's Hospital Melbourne, Australia
- ^{an} Murdoch Children's Research Institute, Melbourne, Australia
- ^{ao} The University of Melbourne, Australia
- ^{ap} Hospital HHA, Universidad de la Frontera, Temuco, Chile
- ^{aq} Department of Pediatric Infectious Diseases and Immunology, Shupyk National Medical Academy of Postgraduate Education and Center for Clinical Immunology, City Children's Hospital NI, Kiev, Ukraine
- ^{ar} Division of Allergy Immunology, Department of Pediatrics, The Children's Hospital of Philadelphia, Philadelphia, PA, USA

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ABSTRACT

Background: X-linked agammaglobulinemia is an inherited immunodeficiency recognized since 1952. In spite of seven decades of experience, there is still a limited understanding of regional differences in presentation and complications. This study was designed by the Primary Immunodeficiencies Committee of the World Allergy Organization to better understand regional needs, challenges and unique patient features.

Methods: A survey instrument was designed by the Primary Immunodeficiencies Committee of the World Allergy Organization to collect both structured and semi-structured data on X-linked agammaglobulinemia. The survey was sent to 54 centers around the world chosen on the basis of World Allergy Organization participation and/or registration in the European Society for Immunodeficiencies. There were 40 centers that responded, comprising 32 countries.

Results: This study reports on 783 patients from 40 centers around the world. Problems with diagnosis are highlighted by the reported delays in diagnosis >24 months in 34% of patients and the lack of genetic studies in 39% of centers. Two infections exhibited regional variation. Vaccine-associated paralytic poliomyelitis was seen only in countries with live polio vaccination and two centers reported mycobacteria. High rates of morbidity were reported. Acute and chronic lung diseases accounted for 41% of the deaths. Unusual complications such as inflammatory bowel disease and large granular lymphocyte disease, among others were specifically enumerated, and while individually uncommon, they were collectively seen in 20.3% of patients. These data suggest that a broad range of both inflammatory, infectious, and autoimmune conditions can occur in patients. The breadth of complications and lack of data on management subsequently appeared as a significant challenge reported by centers. Survival above 20 years of age was lowest in Africa (22%) and reached above 70% in Australia, Europe and the Americas. Centers were asked to report their challenges and responses (n = 116) emphasized the difficulties in access to immunoglobulin products (16%) and reflected the ongoing need for education of both patients and referring physicians.

Conclusions: This is the largest study of patients with X-linked agammaglobulinemia and emphasizes the continued morbidity and mortality of XLA despite progress in diagnosis and treatment. It presents a world view of the successes and challenges for patients and physicians alike. A pivotal finding is the need for education of physicians regarding typical symptoms suggesting a possible diagnosis of X-linked agammaglobulinemia and sharing of best practices for the less common complications.

Introduction

XLA, a primary immunodeficiency disorder (XLA OMIM 300755), was first described in 1952 as a congenital agammaglobulinemia. As one of the

first recognized inborn errors of immunity, it represents a primary immunodeficiency with significant data on outcomes and clinical features. The gene affected in XLA, Bruton tyrosine kinase (*BTX*), was discovered by two independent groups and is located on X-chromosome (Xq21.3—

Xq22).^{1,2} The critical role of BTK in B cell development is evident by the universal B cell deficiency (<2%) and absent precursor B cell differentiation in the bone marrow in patients with pathogenic mutations. Lymphocytes in their blood and tissues fail to generate plasma cells and have severely decreased production of all classes of immunoglobulins with markedly defective antibody responses. B-lineage cells in all organs are affected resulting in reduced sizes of lymph nodes and tonsils.

The genetic understanding is mature and XLA has been identified as the most common cause of agammaglobulinemia. Approximately 85% of patients with early onset of infections, panhypogammaglobulinemia, and less than 2% CD19⁺ B cells in the peripheral circulation have XLA.^{3–8} Autosomal recessive agammaglobulinemia has been associated with mutations in several other genes such as the μ heavy chain gene (*IGHM* MIM 601495), $\lambda 5$ (*IGLL1* MIM 146770), Ig α (*CD79A* MIM 112205), Ig β (*CD79B* MIM 147245), BLNK (*BLNK* MIM 613502), PIK3R1 (*PIK3R1* MIM 615214), and TCF3 (*TCF3* MIM 616941).^{9,10} Autosomal dominant agammaglobulinemia was reported as a result of mutations in the *LRRC8A* gene on chromosome 9q34 and TCF3 gene on 19p13.3.^{11,12} The estimated incidence of XLA ranges from 1:100,000 to 1:200,000 live births.^{13–17}

Early reports of patients with XLA focused on infection as the most common presenting manifestation of XLA.¹⁸ Nevertheless, it is not clear if the specific infections vary from country to country or region to region. In a report from Seoul, Korea, recurrent infections observed included pneumonia, acute otitis media, septic arthritis, skin infection, sepsis, sinusitis, acute gastroenteritis, cervical lymphadenitis, epididymitis, meningitis, osteomyelitis, urinary tract infection and encephalitis. One patient died of hepatocellular carcinoma secondary to hepatitis B virus, an infection not often reported in North America.¹⁹ In Africa, diarrhea was more common than in European cohorts with nearly half of the patients with chronic diarrhea.⁸ Less frequently reported complications of XLA include neutropenia, usually with *Pseudomonas* infection at the time of diagnosis, and the devastating enteroviral meningoencephalitis.^{20,21} Some manifestations may be associated with delay in diagnosis, however, differences in infection pattern may also be related to regional variation in exposure.²² A goal of this study was to identify regional differences in the infection pattern.

With the use of both a patient survey and USIDNET Registry data, 4% of XLA patients were found to have been diagnosed with Crohn's disease in the USA.²³ Arthritis occurred in 16%, a less frequent feature in Italy where it was seen in just 10%²⁴ but seen in 29% of XLA patients reported from China.²⁵ Collectively, the burden of comorbidities impact the quality of life of patients.²⁶ These country or region-specific reports suggest that there may be differences in the clinical features of XLA around the world.

XLA patients are treated with replacement immunoglobulin and prophylactic antibiotics to prevent infections.²⁷ Immunoglobulin may be administered either intravenously (IVIG) or subcutaneously (SCIG) at intervals of 2–4 weeks for the intravenous route and 1–14 days for the subcutaneous route. Recently, a new formulation for the administration of SCIG, using recombinant human hyaluronidase to facilitate the administration of large volumes of SCIG on a monthly basis has been developed.²⁸ The adequacy of IgG replacement is determined by the trough (preinfusion) IgG level in association with the clinical course. Dose adjustment may be needed for excessive infections, growth, enteric loss or increased metabolism. In a meta-analysis, pneumonia incidence declined by 27% with each 100 mg/dL increment in trough IgG and can be progressively reduced by higher trough IgG levels up to at least 1000 mg/dL.^{29,30} The frequency of monitoring depends on age (more frequent monitoring is advisable in younger growing children) and the clinical considerations of the individual patient.³¹ The high cost of this treatment has historically meant that some patients do not receive appropriate therapy.

Immunoglobulin replacement is one of the most significant variables determining risk of infection, however there are clues that there are other mechanisms defining the specific risk profile. BTK has been identified as

a direct regulator of a key innate inflammatory pathway, the NLRP3 inflammasome, and NK cell activation.^{32,33} It is essential for normal TLR-induced IL-10 production in macrophages.³⁴ Other innate functions of BTK have been invoked to explain the unique susceptibility to enteroviruses, however, these data are controversial.^{35–38} The impact of the defective BTK protein is not fully defined but patients exhibit higher than expected rates of inflammatory diseases suggesting dysregulation of the innate immune response.²³ Interactions of the dysregulated innate immune response with colonizing microbes is possible but not yet defined specifically for XLA.^{39,40}

There are multiple potential differences in infectious exposures/microbiome, and perhaps differences in diagnostic approaches and care delivery. Hence, we undertook this survey to understand the diversity of approaches and clinical features in XLA around the world and to call attention to the main management challenges based on a proposal developed by the Primary Immunodeficiencies Committee of the World Allergy Organization (WAO).

Methods

This study was designed and formulated by the WAO Primary Immunodeficiencies committee in 2018 to understand challenges and strengths around the world in the diagnosis and management of XLA. A structured survey instrument was developed and sent to 54 immunology centers around the world defined by participation in the WAO and/or registration with the European Society for Immunodeficiencies. One center had no XLA patients, and in three cases contact information was incorrect. Ten centers did not respond. Forty survey instruments were collected and analyzed using Prism (GraphPad, La Jolla, California). Percents of respondents are generally reported. Fig. 1 displays the location of the centers participating in this survey. Aggregate data was reported from each center and the Children's Hospital of Philadelphia Institutional Review Board determined that such data reported in aggregate did not require consent. The definition of XLA was performed at each center and utilized the ESID criteria.⁴¹

The survey instrument included questions on the features of the centers (health coverage system, the age of the center and the number of living patients followed up), questions relevant to diagnosis (mode of diagnosis and diagnosis lag) and treatment modalities. We specifically queried for cases of inflammatory bowel disease, enteroviral disease, large granular lymphocyte disease, arthritis, chronic cutaneous ulcers (usually due to *Campylobacter*⁴³) and vaccine-associated paralytic polio. We also offered a free text option for other unique and unusual manifestations. Inquiry was made on the average life span, survival above 20 years of age and the cause of death. This study specifically asked centers to delineate their main management challenges. Centers were allowed to list up to three challenges. The challenges were grouped according to the content of the free text.

Results

Characteristics of reporting centers

Data were collected from 40 centers representing 32 countries (Table 1). We asked three questions to understand the care delivery model across the countries: insurance/health coverage, the age of the center and how many living XLA patients are followed at each center. Healthcare coverage was largely skewed towards government coverage: 54% of centers reported comprehensive coverage, 27% reported some government coverage, 7% reported private insurance and 7% reported self-pay. As expected, there was heterogeneity in size and age of the centers although 90% of the centers have been following patients for over ten years, supporting the concept that immunodeficiency is a maturing specialty (Table 2). These descriptive data provide a landscape for understanding healthcare as it relates to the care of patients with XLA.



Fig. 1. A world map is displayed with the approximate locations of the reporting centers indicated with asterisks.

Table 1
Recruitment locations and distribution.

Continent	Country	Number of centers
Europe	Belgium	1
	Czech Republic	1
	Finland	1
	Italy	4
	Northern Ireland	1
	Portugal	1
	Russia	1
	Spain	1
	Ukraine	1
	Subtotal	12
North America	Canada	1
	Mexico	1
	USA	3
South America	Subtotal	5
	Argentina	1
	Brazil	2
	Chile	1
Asia	Peru	1
	Subtotal	5
	China (Hong Kong)	1
	India	2
	Iran	1
	Japan	1
	Kuwait	1
	Lebanon	1
	Malaysia	1
	Pakistan	1
Africa	Turkey	1
	Subtotal	10
	Algeria	1
	Egypt	2
	Morocco	1
	South Africa	1
	Sudan	1
	Tunisia	1
Australia	Subtotal	7
	Australia	1
TOTALS	32	40

Table 2
Center characteristics.

	Percentage of centers
Mean follow-up time of patients with XLA	
<5 years	2%
6–10 years	7%
>10 years	90%
Number of living patients with XLA	
0–5 patients	36%
6–10 patients	19%
11–15 patients	10%
>15 patients	36%

Table 3
Diagnostic and treatment methods.

		Percentage of centers (%)
Diagnostic method	Clinical history and serum immunoglobulins	0
	Clinical history, serum immunoglobulins and flow cytometry	39
	Clinical history, serum immunoglobulins, flow cytometry and molecular studies.	61
Delay between symptoms and diagnosis	<12 months	32
	13–24 months	34
	25–36 months	17
	>36 months	17
Main treatment strategy	Antibiotics for acute infections as the only treatment	2
	Prophylactic antibiotics without immunoglobulin replacement	0
	Immunoglobulin replacement	98
	Hematopoietic stem cell transplantation	0

Diagnosis and management options

Four questions established the mode of diagnosis at each center and the treatments most frequently utilized (Table 3). All centers used flow

cytometry for diagnosis but genetic testing was widely utilized as well (in 61% of centers). The lag from the time of first complaint to diagnosis varied widely with 34% of centers reporting delays of more than 24 months. The delay was not related to type of health insurance coverage (ANOVA analysis not significant). Nearly all centers (98%) utilized immunoglobulin replacement as their main treatment, however access to subcutaneous immunoglobulin (SCIG) was reported by only 61% of centers.

Survival

Most centers (78%) reported that patients with XLA had a good survival rate with an average life span of over 15 years of age, however, only 62% of centers who saw adults reported that >75% of their patients with XLA survived beyond 20 years of age. The causes of death were highly varied. Eleven centers reported no deaths. There were 46 causes of death reported. Among the listed causes, chronic lung disease or acute lung disease were the most common 19/46 (41%). Sepsis was listed for six deaths (13%). There were six deaths from CNS infection/enterovirus (13%). Two patients had colitis listed as a cause of death. The remainder of the distinct causes were listed only once (cachexia with concomitant TIMM8A deletion, aneurysm, stomach cancer, hepatitis C, among others). When we assessed regional effects on survival, there were clear differences by continent (Table 4).

Unusual complications

This large cohort of patients with XLA allowed us to define the frequencies of complications previously reported in small series or case reports and to explore whether there is regional variation (inflammatory bowel disease, enteroviral disease, large granular lymphocyte disease, arthritis, chronic cutaneous ulcers (usually due to *Campylobacter*⁴²) and

Table 4
Regional differences in XLA.

	Survival >20y of age ^a	Enteroviral meningoencephalitis	Inflammatory bowel disease	Arthritis
Africa n = 229	22%	1.3%	1.3%	8.3%
Asia n = 169	39%	0.59%	2.4%	6.5%
Australia n = 7	>75%	0	0	14.3%
Europe n = 186	>75%	0.54%	5.9%	17.2%
North America n = 136	75%	0	2.2%	2.9%
South America n = 56	72%	10.7%	8.9%	7.1%

^a Survival was based on a weighted average of reported categorical responses.

Table 5
Infrequent manifestations of XLA.

Complication	Cases reported	Percentage of reported cohort N = 783	Data from other publications ^{8,14,18,19,24,25,43–52}
Inflammatory bowel disease	27	3.4%	2.27%
Enteroviral meningoencephalitis	36	4.6%	4–38% ^a
Large granular lymphocyte disease	1	0.1%	–
Arthritis	62	7.9%	7–29%
Chronic cutaneous ulcers	6	0.8%	6–28% ^b
Vaccine-associated paralytic polio	12	1.5%	3% 1%

^a Meningitis/encephalitis. Could be enteroviral disease, bacterial meningitis or autoimmune conditions.

^b Reported as skin involvement.

Table 6
Challenges.

Challenge	Percent of responses N = 116
Access to immunoglobulin	16%
Delay in diagnosis/Access to diagnostic tests/Awareness	16%
Compliance	14%
Access to subcutaneous immunoglobulin	7%
Pathogen detection and therapy for specific pathogen	7%
Transitioning to adult providers	6%
Financial burden	5%
Enteroviral infections	3%
Psychological support	3%

vaccine-associated paralytic polio). We also offered a free text option for other unusual manifestations. There were 12 occurrences of vaccine-associated paralytic poliomyelitis with only one reported from Europe and none from North America (Table 4). There were 62 cases of arthritis and 10 of those were from Russia, a significant enrichment. Otherwise, there was no clear evidence of regional variation. (Table 5).

Among the free text listings, none were listed more than once. Norovirus, campylobacter, and hepatitis C were each listed once as specific infections. Conjunctivitis, autoimmune enteropathy, cholangitis, autoimmune hemolytic anemia, and sarcoid were each listed once as inflammatory conditions.

Challenges reported by centers

We recognized that each center could have unique aspects related to patient care that were not predictable and we offered centers the opportunity to define their biggest challenges and unique patient features using a free text response (Table 6). Regionally unique aspects of care included mycobacterial infections in Argentina and India and vaccine-associated paralytic polio in countries that use the live polio vaccine (Table 4). The challenges were grouped according to the content of the free text. Centers were allowed to list up to three challenges. Immunoglobulin access, awareness of XLA/delay in diagnosis/diagnostic test access were the most common concerns listed at 16% of total responses each. Six centers listed cost to the patient as prohibitive or limiting. These centers were located in countries with incomplete government coverage and were located in North America, Asia, and Africa. Other common responses were compliance, quality of life issues and transition of care. Enteroviral infections, inflammatory diseases, conjunctivitis and management of lung disease were listed by at least two centers. These concerns ranged from pragmatic aspects of patient care such as management of rare complications, to pleas for improved education regarding recognition of XLA, to government policy regarding immunoglobulin.

Discussion

To understand the current landscape of regional variation in XLA, we performed a survey to understand diagnostic approaches, available therapies and regional complications. This WAO survey achieved a remarkable reportage from 32 countries widely distributed around the world. This is the largest series of XLA patients reported to date. We compared our data to published series of patients with XLA (Table 7).^{8,14,18,19,24,25,43–52} Notable differences across reports were the frequency of neutropenia ranging from 1 to 22% among those who reported this feature. Meningoencephalitis was reported in 4–38% of patients at different centers although pathogens were rarely reported. Therefore, these could have represented enteroviral disease, bacterial meningitis or autoimmune conditions. Our survey identified enteroviral disease in 4.6% of patients consistent with that seen in other reports. Arthritis was reported in our survey in 7.9% while it was reported from other centers as 7–29%. Orchitis, an unusual clinical feature in XLA, was reported in significant numbers from two centers and was not specifically queried in our survey. Thus, the data from this survey are consistent with previous

Table 7

Analysis of published case series of patients with XLA.

Country (Reference)	(N)	Age -presentation	Age at diagnosis	Presenting manifestation	FH	Pneumonia (%)	GI disease (%)	Meningitis/ encephalitis	Otitis	Other	CLD (%)	Deaths (%)	BTK mutations
Algeria ⁴⁴	9	15 m	6.7y	100% Respiratory infections	22%	100%			22%	22% Neutropenia 11% Arthritis 11% Skin infection	77%		66.6%
Iran ^{45,46}	30					67%	27%	20%	63%	20% Septic arthritis 13% JIA 10% Neutropenia	17%		
Morocco ⁸	50	10 m	4y		32%	92%	42%	27%	47%	37% arthritis 10% osteomyelitis	15%		79%
France ⁴⁷	31	7 m		84% Infections	16%	48%	10% Enteropathy	10% Enteroviral		13% Chronic sinusitis 3% Orchitis 3% Septic Arthritis 22% Aseptic arthritis 6% Skin	19%	3.2%	83.8%
Italy ²⁴	73		3.5y	68% Respiratory infections	40%	53%	19% Gastroenteritis	4%	50%	48% Chronic sinusitis 27% Skin 10% Arthritis 3% VAPP 1% Neutropenia	33%	1.4%	100%
Netherlands ⁴⁸	15	14 m	6.5y			100%	73% Gastroenteritis 47% Giardiasis	27%	53%	67% Sinusitis	80%	33%	26.6%
Poland ⁴³	44	13 m	3.7y	73% Lower respiratory infections		59%	64%	14%	41%	34% Sinusitis 16% Arthritis 14% Skin abscesses	27%	4.5%	100%
Portugal ⁴⁹	9	13 m	3.4y	89% Infection	11%	56%	33% Giardia		78%	33% Neutropenia 22% Septic arthritis	22%	0%	100%
Spain ⁵⁰	30	23 m	6y		55%								83%
United Kingdom ⁵¹	69		2.2y		62%	67%	16%	17%		17% Skin 6% Septic arthritis 16% Aseptic arthritis 29% arthritis 3% vaccine-associated polio			
China ²⁵	62	24 m	7y		40%	73%	29%	13%	37%	26% Septic arthritis 26% Skin Infection 21% Sinusitis	5%	10.5%	42%
Korea ¹⁹	19		4.9y		31%	68%	16% Gastroenteritis	16% Meningitis 5% Encephalitis	32%				
Mexico ⁵²	26					69%	19% Diarrhea 4% Colitis	38%	61%	57% Sinusitis 38% Septic arthritis 11% Skin abscesses 28% Skin			100%
USA ¹⁸	96	10 m	2.9y	65% Lower Respiratory 75% ENT	55%	65%	35%	16%	59%		70%	17%	
USA ¹⁴	201	12 m	4y	86% Infection	58%	62%	23%	12%	70%	60% Sinusitis 8% Orchitis 18% Skin 11% Neutropenia 7% Septic arthritis 1% VAPP		8.5%	59%

FH: Family history; GI: gastrointestinal; CLD: chronic lung disease; JIA: juvenile idiopathic arthritis; VAPP: vaccine associated paralytic poliomyelitis.

reports but greatly expand the understanding of the overall landscape of patients with XLA.

Infections are a major clinical indicator of XLA. The original description by Colonel Ogden Bruton depicted a boy with recurrent sepsis, pneumonia and otitis media.^{53,54} Respiratory tract infections constitute a prominent and ongoing clinical problem despite immunoglobulin replacement therapy. In one study, the overall probability of developing chronic lung disease reached about 80% after 17 years of follow-up.²⁴ Gastrointestinal disorders, mainly diarrhea were reported almost as often as lower respiratory tract infections in Poland whereas inflammatory bowel disease was diagnosed quite infrequently.⁴³ In India, the most common infection noted was pneumonia.⁵⁵ The summary of features from many countries in Table 7 highlights the continuing pattern of significant and life-altering infections. Chronic lung disease and sepsis were the two most common causes of death, in this survey, suggesting that management continues to fall short for some patients. Nevertheless, there is cause for cautious optimism as nearly all centers had access to immunoglobulin even if access was complicated and gaps occurred. Over half of the centers reported that the majority of their patients were reaching adulthood.

Patient survival was highly regional, reflecting healthcare challenges in countries with emerging economies. Several centers commented on the difficult logistics for patients with only a single center in some countries offering diagnosis and treatment. The Eurodis survey noted patients with rare diseases lack access to local care in many European countries.⁵⁶ Improving education of the primary care physicians managing patients locally was a key need noted by several contributors. Efforts to provide printed materials in various languages could benefit many patients and increasing use of technology to support primary care physicians will be increasingly important. Lack of education is also related to delays in diagnosis. When primary care providers understand the clinical features they are more likely to refer for diagnostic testing.⁵⁷ Although a number of efforts have been instituted to improve awareness and recognition of inborn errors of immunity, it appears that additional efforts could have a substantial benefit.⁵⁸

This study examined uncommon complications, leveraging the large sample size and the expertise of the contributors. In this regard, we were able to identify a higher than anticipated frequency of these complications collectively. Enteroviral disease,²⁰ including vaccine-associated paralytic polio is still occurring (12 patients). This ruinous complication is possibly related to delayed diagnosis.²⁰ Whereas inflammatory bowel disease was diagnosed quite infrequently (1/44 (2.3%) in one center⁴³), this study showed a frequency of 3.4%. Complications such as cutaneous ulcers (often due to *Flexispira* or *Campylobacter*), inflammatory bowel disease, large granular lymphocyte disease and arthritis are not thought to be related to lack of treatment, although the specific risks for these infrequent complications are not known.^{23,42,59} *Mycoplasma* or *Ureaplasma* arthritis may occur more often in untreated or sub-optimally treated patients.^{60–62} The overwhelming sense from this survey is that these “infrequent” complications collectively affect a significant number of patients with XLA. Nearly 20% of patients had one of these “infrequent” complications. In the free text fields, centers noted struggles to treat unusual infections, unusual autoimmunity, and to coordinate multiple specialties for complex patients. These challenges are universal and not clearly related to geography, type of insurance, or size of the center. Our findings support development of a world-wide community of immunologists to share best practices for rare complications.

Our overall goal was to examine regional differences in diagnostic testing, therapies, and clinical manifestations. In fact, we uncovered relatively few regional differences with vaccine-associated paralytic polio being perhaps the only complication with a clear regional component, wholly related to exposure. Mycobacterial infections also seemed to have a regional effect.

We offered respondents the opportunity to describe their main challenges and many responses were not purely medical. Compliance with medications, transitioning of patients to adult providers and education of

patients ranked very high among the cited challenges in our survey. As centers move from the original concern of keeping patients alive, now the focus has fittingly moved to optimization of health. These concerns were surprising because they require time and focus but little in the way of technology or other resources that are often limiting. There are few guidelines for the transitioning specifically for people living with inborn errors of immunity.⁶³ Some progress has been made in developing guidelines for transitioning of children with chronic illness and these may be applied, although a destination adult-care clinic is still central to the process^{64,65} and often lacking.

Limitations of this study are the use of a non-validated survey instrument that was focused on specific outcomes and questions. The aggregations of the free text responses may have imposed an interpretation not been intended by the responder. Additionally, this survey did not reach every country. There is likely additional heterogeneity in responses not captured in this survey. Representation from East Asia was relatively weak and Southern Africa was represented by a single center. Nevertheless, this study provides an important framework for strategically considering diagnostic testing and treatment approaches that could be mandated by the World Health Organization. The World Health Organization already includes immunoglobulin as an “Essential Medication”.⁶⁶ This is the largest cohort of patients with XLA ever reported and provides critical information on medical concerns as well as challenges to meeting the next goal of a full and healthy life for all patients.

In summary, this survey conceptualized by the WAO in 2018, demonstrated key findings. Most patients are surviving to adulthood and infections continue to be the most frequent manifestation. Access to immunoglobulin replacement is fairly uniform but centers reported frustrations with lack of subcutaneous immunoglobulin, the high cost of immunoglobulin and the logistical aspects of obtaining and delivering immunoglobulin. This survey highlighted the less frequent complications and supports development of a multinational registry or communal blackboard to share treatment approaches and to study outcomes. Strategies to share practices on transitioning and education of primary care and other referral sources is a critical need and one in which resource sharing could be beneficial.

Conclusions

Survival of patients with XLA is good globally, however, this study revealed a surprising burden of morbidities with nearly 20% suffering from what have been considered unusual complications. Centers identified a number of challenges in providing care for patients including access to immunoglobulin in a manner that is financially achievable, logistically feasible, and respectful of patients' time. Other challenges included education of patients and primary care physicians and the transitioning of patients to adult centers. Overall, this study supports better efforts to share best practices internationally, and suggests that there is much to be done to optimize patient care.

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Consent for publication

Not applicable.

Conflicts of interest

The authors declare that they have no competing interests.

Availability of data and materials

The dataset is available from Kathleen Sullivan.

Ethics

The Children's Hospital of Philadelphia Institutional Review Board determined that data reported in aggregate did not require consent.

I confirm that each author has contributed in a substantive and intellectual manner. This manuscript has not been submitted elsewhere. No commercial financial support was utilized. The authors declare that they have no competing interests.

ZAE-S, EH, and KES conceived and designed the study. ZAE-S and KES wrote the manuscript with assistance from all co-authors. IA, JCA, WA-H, LB, RB, AAB, CC, AC-N, GD, BD, FD, JDME, BE, RHE-O, SEEP, NG, FH, RH-W, AI, EK, HK, NK, YLL, TM, VM, JFN, MO, RP, KP, CP, AP, FNQ, SQ, NRa, NRe, NRo, JR, BS, AS, MRHS, EGS, AS, SSing, SSini, GS, MT, AMV, AV performed data analysis and review.

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